Blue Cross of Idaho

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2015 State of Idaho Health Qualification Form

Member Information *(complete and sign)*

Member Name *(Please print)*		Blue Cross of Idaho Subscriber ID Number *(9-digit number)*
Date of Birth *(mm/dd/yyyy)*	Sex: ❑ Male ❑ Female	Telephone Number
Employer Group Name **State of Idaho**		Group Number **10040000**
Member Signature		Date

Healthcare Professional providing this service *(complete and sign)*

Provider Name *(Please print)*	Telephone Number	State License Number or National Provider ID (NPI)
Provider Signature		Date

Healthcare Provider: Please provide your information above and complete the health measures below.

Health Measure	Initial Evaluation	Values (Required)
Tobacco Use Patient is tobacco-free	Check one ***(required)***: ❑ Yes ❑ No	Assessment Date: _____
Blood Pressure (10 points) BP ≤ 140/90	Check one ***(required)***: ❑ Yes ❑ No	Measurement Date: _____ BP Value: _____
Cholesterol (10 points) *(measured by total cholesterol or high-density lipoprotein)* Total cholesterol < 200 or HDL ≥ 40 (male) or 50 (female)	Check one ***(required)***: ❑ Yes ❑ No	Measurement Date: _____ Total Cholesterol: _____mg/dl Triglycerides: _____mg/dl HDL: _____mg/dl LDL: _____mg/dl
(10 points) Triglycerides ≤ 150	Check one ***(required)***: ❑ Yes ❑ No	
Weight (10 points) *(measured by body mass index or waist circumference)* BMI ≤ 28 or waist ≤ 35 (female) or ≤ 40 (male)	Check one ***(required)***: ❑ Yes ❑ No	Measurement Date: _____ BMI: _____ Waist: _____inches Height: _____ft._____ inches Weight: _____lbs.
Blood Sugar (10 points) *(measured by fasting blood sugar or hemoglobin A1c)* FBS ≤ 110 or A1c ≤ 5.8 if non-diabetic or A1c < 7 if diabetic	Check one ***(required)***: ❑ Yes ❑ No	Measurement Date: _____ ❑ Non-diabetic ❑ Diabetic FBS: _____mg/dl OR A1c: _____%
Member follow-up: ❑ 3 months ❑ 6 months ❑ 1 year ❑ as needed		**Members total points**_____

This information is confidential and your results will not be shared with your employer. The signed parties agree that all of the information supplied is complete and accurate. Make a copy of this completed form and keep for your records.

Instructions to Member: Please complete and sign your portions of this form and obtain the necessary information and signature from your healthcare provider. **Refer to your Blue Cross of Idaho health insurance ID card to complete the fields on the front of this form.** ***Mail the completed form to the address indicated on this form.***

Instructions to Healthcare Provider: Please check the appropriate box for each health measure located on the chart on the front of this form. Include dates, readings, comments under the "Values" section below. Then total the points, sign this form, and give completed form back to your patient. **Please submit the claims identifying the preventive visit as a wellness service to ensure the office visit falls under your patient's preventive care benefit.**

Note to Member: We are committed to helping you achieve your best health. The information from your Health Qualification Form is strictly confidential and will not be shared with your employer. Blue Cross of Idaho will only inform your employer of your qualification status.

Source: Blue Cross of Idaho bases ranges on clinical guidelines available to members and providers on the Blue Cross of Idaho website at ***bcidaho.com.***

Questions about this form?
Contact Blue Cross of Idaho Customer Service by phone at **208-331-8897 or 866-804-2253**
or email inquiries to: **CustomerService@BCIdaho.com**

Mail a copy of completed form to:
Blue Cross of Idaho, Attn: thrive**idaho**/HQF, P.O. Box 7408, Boise, ID 83707-1408
or Fax Toll Free to: 800-471-4424 or Scan & Email to: *thriveidaho@bcidaho.com*

Reminder to Healthcare Professionals: Please submit the claims identifying the preventive visit as a wellness service to ensure the office visit falls under your patient's preventive care benefit.